



Original communication

Challenges experienced by service providers in the delivery of medico-legal services to survivors of sexual violence in Kenya

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ABSTRACT

While much discussion has been devoted to defining the standards of care required when offering services to survivors of sexual violence, much less attention has been given to procedures for evidence collection to allow the successful prosecution of perpetrators. In Kenya there are no comprehensive guidelines that outline the roles of the survivor, the community, health care workers, and the police with regard to the handling of forensic evidence, a deficit that contributes to delays in prosecuting, or even a failure to prosecute sex offenders. This study examines some of the obstacles in Kenya to the adequate handling of forensic evidence in sexual violence cases. It was based on in-depth interviews with respondents drawn from health facilities, police stations, civil society organizations and with the Government Chemist in three Kenyan provinces. The study's objective was to examine the existing policy requirements regarding the maintenance of an evidence chain by the health and criminal justice systems, and how effectively they are being implemented. The findings indicate that the quality of the evidence obtained by the health care workers was often deficient, depending on the time elapsed before the rape survivor reports to the health facility; the equipment available at the health facility; the age of the survivor; and the level of knowledge of the service provider regarding the types of evidence to be collected from survivors of sexual violence.

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1. Introduction

Sexual Violence (SV) is a serious societal problem that creates significant challenges to local communities in their attempt to create an overall plan for meeting the medical, emotional, physical safety and legal needs of survivors.¹ Issues of SV cannot be addressed in a vacuum by concentrating solely on the medical and psychological needs of the victim, important as this is; it is also imperative to understand and recognize the links between the health sector and the criminal justice system.² Appropriate management of survivors requires a standardized clinical evaluation and an effective interface with law enforcement for the handling of forensic evidence and coordination of the continuum of care.

The process of obtaining, preserving and conveying evidence through accountable tracking mechanisms from the health facility to the police has been called a "chain of evidence."³ It encompasses mechanisms put in place to ensure that the collected evidence is air

dried, sealed in separate containers to avoid cross contamination, labelled, signed and dated by the person(s) who collected it from either the health facility and/or police.⁴ Maintaining a chain of evidence is as important as collecting the right evidence at the outset, since without rigorous documentation the collected evidence is usually considered inadmissible in court.

The role of medico-legal services in the management of survivors of SV is well documented.⁵ Medical evidence is essential to confirm or disprove a link between the alleged perpetrator and the assault.⁶ It is the bridge that links the health and criminal justice systems in the care and management of survivors. An efficient system requires a chain of evidence that allows forensic (medico-legal) evidence collected from the health facility to proceed to a forensic laboratory for analysis and hence to the police for action.^{7,8} Research indicates that the training of service providers does not necessarily increase their ability to collect the required specimen and maintain the evidence chain. Studies show that health care providers often deviate from the standardized service delivery protocols depending on the case at hand. Studies have also shown that there is a tendency for such forensic evidence to be poorly collected and poor

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communication between police, forensic analysts, and medical personnel serves to inhibit the effectiveness of the whole process.⁹

Kenya has scant literature detailing the requirements of maintaining the evidence chain with established linkages between the health services, the police and the community. Although the police follow a standard procedure in SV cases, it appears to be a matter of convention rather than written rule as there are no documented protocols to be observed. Within the health facilities, evidence gathering from survivors by the examining health care worker does not always produce enough details to provide corroborative evidence, due to the lack of utilization of the proper documentation. In rural communities, the existence of parallel justice systems in the form of traditional courts further increases survivors' vulnerability. Medical attention is not given priority in such systems and perpetrators are often asked to pay fines. Sexual violence is often viewed as an individual and/or private act. This customary framework puts blame on individual survivors (and individual abusers), thus keeping these violations out of the public eye and beyond the boundaries of collective action and responsibility.¹⁰ The role of community interventions has hitherto largely been ignored, yet SV often occurs within the physical environment of the community where community members are potential witnesses.

Maintenance of the evidence chain is the most critical interface between medical and legal sectors and it is clear that it has been neglected. Little attention has been given to examination and documentation of SV, especially handling of evidence by officers of the criminal justice system, clinical and laboratory staff.¹¹ The absence of national minimum standards on the maintenance of the evidence chain compounds this problem. The effects of the lack of a forensic medicine system in Kenya are worsened by legal requirements that only doctors can give evidence, in an environment where there is a dire shortage of doctors across the range of public health facilities.

Through the Post Rape Care (PRC) services offered to survivors in the public health and legal sectors concerns have emerged over the existing linkages between the criminal justice system and the health care facilities in Kenya. Survivors have complained about delays in, or lack of prosecution, and the dismissal of their cases by the courts when the latter pronounce evidence presented by the police (who in Kenya also play the role of prosecutors) inadmissible.¹² This article reports on a study aimed at establishing the existing and required practical policy requirements of maintaining an evidence chain by the health and the criminal justice systems in the context of PRC in Kenya. The current practices and gaps in the collection, storage, analysis, documentation and transportation of evidence collected from survivors at the hospitals are described.

2. Methodology

Liverpool VCT, Care and Treatment (a Kenyan non-governmental organisation) conducted an operations research study in government run health facilities in three provinces: Nyanza, Eastern and Nairobi. The facilities were intentionally selected due to their collaboration with the district police administration in the selected regions, and because they had functioning laboratories and PRC services. The health care workers were trained in physical examination of survivors and documentation procedures in evidence collection, and police officers in these regions had been sensitized on various aspects of SV.

The study participants were selected so as to include respondents who were involved in the provision of medical, psychosocial and legal support to survivors of SV. Snowballing (a sampling procedure where one respondent who is successfully recruited into

Table 1
Respondents by designation.

Study Location	Designation	Male	Female	Number of Respondents
Nyanza	Clinical Officers	2	1	3
	Medical Officer	1		1
	Counsellor/Nurse		1	1
	Nurse In Charge	1		1
	Laboratory Officers	1	1	2
	Police Officer		1	1
	Police Constable	1		1
Eastern	Clinical Officers	3		3
	Medical Superintendent	1		1
	Nurse		2	2
	Laboratory Officers	1	1	2
	Police Officer	2		2
Nairobi	Counsellor/Social Worker		3	3
	Laboratory Analyst	1	1	2
	Legal Officer	1	3	4
Total		15	14	29

the study suggests others known to him/her who might similarly be eligible) was used to identify potential respondents.

In-depth interviews were conducted to capture the participants' experiences in the delivery of PRC services with a focus on evidence retrieval from survivors. The interviews were taped upon receiving oral and written consent from the respondents.^c Data was collected during September 2007 from two district hospitals, two police stations, three civil society organizations, and the national Government Chemist. It was not possible to interview all the health care workers in the study sites who had been trained on the delivery of services to survivors of SV. Some of the respondents who were eligible to participate in the study were not recruited as they had not been actively involved in the delivery of PRC services, but were stationed at service delivery points where PRC services were being offered. Table 1 below shows the respondents by designation.

Data was thematically coded using NVIVO7, a qualitative data analysis software. The main themes documented were: the evidence collected; the storage of specimens; the type of analysis done; the place where analysis was performed; how the process was documented, and how specimens were transported to the Government Chemist.

3. Findings

From a study of the respondents' replies to the questions raised in the interviews, four issues can be identified that negatively affect the evidence chain and consequently the ability of the Kenyan criminal justice system to respond effectively to the scourge of sexual violence: lack of clarity and uniformity in practitioners' definition of sexual violence, flawed evidence collection, difficulties in collecting samples, and bottlenecks caused by the shortage of doctors. These are dealt with in succession below.

3.1. Disparate definitions of sexual violence

The Kenya Sexual Offences Act (SOA), which has been in force since 2006, provides clear definitions of the various types of sexual

^c Ethical approval for the study was granted by the Kenyatta National Hospital Review Board. Permission to recruit the participants was obtained from the relevant authorities in the health sector, police and the civil society organizations. The participants' names were not recorded or indicated in the transcripts, and they were free to terminate their participation at any point in the study. All the research assistants followed standard research etiquette and procedures, such as keeping the tapes, transcripts and field notes under lock and key.

offence. This Act expanded the definition of rape to include penetration by other objects in addition to the penis. It also consolidated all laws relating to sexual offences in Kenya, while clearly defining the various types of sexual offences recognisable within the Kenyan legislative framework.

Despite the definitions contained in the SOA and the fact that the study was undertaken three years after the law was enacted, the respondents gave various different definitions of SV. Most described SV as acts that occur without the subject's consent, as in the following examples:

"SV is any sex that is obtained by force on receiver."—Clinical Officer, District 01.

"I think it's getting access of the private parts of the individual without the person's knowledge [without one's consent]."—Nurse In Charge, Laboratory, District 02.

"Sexual violence in my opinion is any forceful gestures when someone who wants to have sex with someone else without his or her consent...which can be physical or non-physical... it can just be word of mouth or it can proceed to be forceful."—Paediatric Ward Nurse, District 01.

Most of the respondents did not use the definitions in the Sexual Offences Act.¹³ The statutory terms to define SV include rape; attempted rape; sexual assault; indecent acts; defilement; promotion of sexual offences with a child; incest; sexual harassment, among others. The fact that most respondents did not use the SOA terms has medico-legal implications for the kind of documentation assembled and maintained about the offences reported by survivors. In cases where different health care workers stationed in different service delivery points handle the same survivor this could result in discrepancies in describing the complaint presented by the survivor. The use of terms that do not match the legal definition pose problems for prosecution especially if the survivor's account varies from the details documented in the clinical notes and the occurrence book at the police station. This can result in the dismissal of cases due to variations in the survivor's testimony and the clinician's documentation; doubts about the credibility of the medical doctor; and lack of trust in the medico-legal system among the public which could affect victims' willingness to report sexual abuse. A social worker highlighted how lack of clarity about the law by medical workers or the police can affect prosecutions:

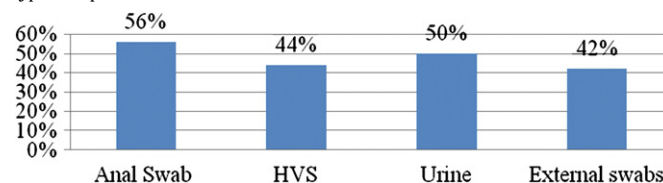
"...most of the time the child is not lying, you see, but at times the evidence collected is not sufficient to show that there was an offence, especially after the sexual offences were repealed from the penal code,^d and are now in the act [SOA], some prosecutors did not reflect that on the charge sheet.... I have seen one case like this so they did not amend the charge sheet and in the end the magistrate had no other choice but to throw out the case." (Social Worker, District 03)

3.2. Flawed evidence collection

According to the Kenyan National Guidelines on the Management of Sexual Violence, the samples health care workers are required to obtain from survivors include urine, clothing, swabs (vaginal, anal and oral swabs), bite marks, liquid blood, pubic and head hair, sanitary pads, and nail and skin scrapings. Despite these requirements, during the study respondents mentioned that they only collect High Vaginal Swabs (HVS), rectal swabs (in case of

Table 2

Types of specimens collected from survivors.



sodomy), urine, blood, and the clothes worn during the assault. The types of specimens collected were dependent on the survivor's age and sex. For example, some of the health care workers mentioned that they faced challenges in obtaining an HVS or rectal swab in child and male survivors of sexual violence respectively due to lack of skill or knowledge in how to undertake this process. This in itself highlights a key challenge in prosecution of cases relating to child and male survivors due to a lack of corroborative evidence. A clinical officer explained the procedures used in the following terms:

"—you see they are not used to such kind of examinations, so they tend to...they are shy, so like some you end up getting the wrong specimen, instead of getting the high vaginal swab, you end up getting the outer swabs" (Clinical Officer, Casualty, District 01)

"—for kids it [evidence collection] becomes complicated because you[health care worker] don't have any speculum for kids, even you can't insert a speculum on a kid surely" (Clinical Officer, District 02)

This scenario was also noted in an analysis of the PRC forms^e maintained for survivors of sexual violence as shown in Table 2:

The Kenyan National Guidelines on the Management of Sexual Violence clearly stipulate the type of swabs to be obtained from children and adults, whether the hymen is broken or not. In the case of children they state that "in most cases a speculum examination is not indicated. It is only indicated when the child may have internal bleeding arising from a vaginal injury as a result of penetration. In this case, a speculum examination should be done under general anaesthesia."⁵ However, implementation of these guidelines is uneven. In one health facility, the respondents mentioned that HVS's were not collected from child survivors because the health care workers did not have enough skills to retrieve such evidence from children. The health care workers therefore relied on the child's or parent's story which in some cases could not be corroborated by the evidence.

These inadequacies in evidence collection illustrate a lack of knowledge by health care workers of the importance of medico-legal proof of sexual abuse, increasing the difficulty of obtaining positive case outcomes by the criminal justice system. This is reflected in the excerpt below:

Interviewer: Are there any cases where a suspect is acquitted on the basis of shortcomings in the evidence chain?

Respondent: A lot of times it happens because the medical evidence submitted was not sufficient to show if there was any penetration, or anything like that... and the evidence provided should go beyond reasonable doubt and if there is reasonable doubt, then the case wouldn't proceed. (Lawyer, District 03)

^d The Penal Code is the backbone of the criminal justice system in Kenya. It defines criminal offences and prescribes the corresponding penalties.

^e The PRC1 form is a Ministry of Health document that serves the purpose of providing an avenue for collection and documentation of evidence required in court and as such forms an integral part of the legal documentation of medical management of survivors as they pass through the health care system.

3.3. Challenges in collecting samples

The World Health Organisation guidelines for the medico-legal care for victims of sexual violence indicate that health facilities ought to have the following minimum equipment to facilitate the provision of services to survivors of SV: a couch, swabs, blood tubes, speculums, pregnancy kits, a sharps container, microscope slides, vercutainer tubes, syringes, and gloves.¹⁴

However, health care workers interviewed were found to experience various challenges in retrieving specimens from survivors, including unavailability of proper and adequate equipment; lack of knowledge on how to use a speculum; and lack of appropriate facilities to analyse samples at the district health facility level. The district public hospitals could only analyse blood (for HIV test), urine (for pregnancy), and HVS/Rectal swabs (for Sexually Transmitted Infections or to detect spermatozoa). In certain instances the survivor's version of the complaint was the only evidence found to be available as samples could not be collected due to delays in health facilities obtaining supplies of equipment from the Kenya Medical Supplies Agency.^f As a clinical officer acknowledged: *"Forensic we do, although we have some handicaps in that, like the kind of lighting system... Also some examination equipment we have... are not up to date"*. (Clinical Officer, Casualty, District 01)

Many of the health care workers interviewed lacked skills in retrieving samples from child survivors. Inconsistencies in the accounts of sexually assaulted children during examination were common in situations where the child was required to tell the same story to different service providers. Some children feel uncomfortable if attended to by physicians of the same gender as the perpetrator. There are instances in which health care workers are required to obtain high vaginal swabs from children, yet the health facilities are not stocked with the equipment needed to facilitate this. The use of speculums in children also is not a standard requirement. These challenges contributed to inadequacies in the type of evidence collected from children. Moreover, comments by several respondents suggested nervousness and lack of procedure in dealing with child victims. As a medical superintendent put it: *"Children are a special group, they are difficult to handle. Because, number one, they are traumatised. A child who has been sexually assaulted does not even want to see any male around"*. (Medical Superintendent, District 02). Another respondent indicated that children are only admitted at the health facility to facilitate sample collection once they calm down. While this may seem sensible if the children are visibly distressed it may also have implications for evidence collection.

The absence of supporting evidence was another challenge. There were instances in which survivors presented with a case of SV but there was no supporting evidence from laboratory either due to lack of physical evidence suggesting rape or because the perpetrator used a condom, or was suffering from azoospermia. A nurse explained the difficulty as follows:

Suppose you examine a client, there is no evidence of violence, so from there I send somebody to the laboratory, he comes back, there are no laboratory results suggesting sexual assault.... Maybe the same client goes to court, there is nothing suggesting such an occurrence. From there you have a lawyer who questions the occurrence of the assault since the survivor's story is not corroborated by the medical evidence. (Nurse, Comprehensive Care Clinic, District 02).

Police officers were also found to lack the skills required to enhance proper collection and handling of evidence from survivors of SV. As a lawyer explained in an interview, illustrating the challenges faced by lawyers in court:

...another thing that happens is the police investigation, they could do a lot better because by the time they go to court they aren't well prepared, the collection of evidence is sometimes not done well, they don't meet certain things, in the end the person ends up being acquitted, yet he may have very well committed the offence. (Lawyer, District 03)

Some of the challenges faced by health care workers and police officers were found to be tied to a lack of community awareness about the medico-legal services available following sexual assault. This lack of information could explain why some survivors of SV present themselves at the health facility seeking care several days after the sexual assault. Delayed reporting contributes to the failure to collect evidence that would aid in prosecutions. It also increases risks of HIV/STI infection, unwanted pregnancies, and post stress traumatic disorders following sexual abuse.¹⁵ A laboratory technician told an interviewer: *"...sometimes we try to explain...to advise them...that once they are assaulted they should come to the hospital immediately. You know some wait for a long time...so even if there was like spermatozoa it would not be seen"*. (Laboratory Technician, District 01). Delays in sample collection were also experienced in cases where the survivor presented at night when the laboratory, where the refrigerator is located, is closed. The challenge for health care workers was to decide whether all survivors who presented at night should be admitted overnight or go back home and return the following day, hopefully with the evidence intact.

3.4. Shortage of doctors

In the health facilities there is often only one medical doctor who also has administrative responsibilities that further limit the time available to attend to patients. Yet, it is an established practice in Kenya that only medical doctors can act as "expert witnesses" in cases of SV. If a survivor is examined by any clinicians other than a doctor, the evidence can be challenged in court. For this reason, some of the clinicians chose not to fill in the required medico-legal documents on behalf of the doctor. As one clinical officer explained: *"...but most of us when there is a case of rape, and a certain doctor in not there, you see, they [survivors of SV] cannot be handled properly"* (Clinical Officer, Mother-Child Health Clinic, District 02).

4. Discussion

Rape and all types of sexual offences in Kenya are considered to be crimes against the state. Health care workers play a key role in aiding in retrieval of evidence that would be used by the police in prosecuting cases of SV. Such medico-legal evidence is paramount in aiding the criminal justice system to carry out a thorough and impartial investigation of rape cases. Existing literature suggests that cases of sexual violence where evidence is collected and well documented are more likely to move forward in the criminal justice system than in cases where such evidence was not collected. A study undertaken by Jewkes et al demonstrates that proper documentation of the medico-legal examination procedures is more likely to result in positive legal outcomes.¹⁶ However, in Kenya, the continued inability by HCWs and police to collect evidence from survivors in a timely and effective manner continues to have a negative impact on the successful prosecution of cases. These factors help explain how, according to the available statistics, only about 25% of SV cases prosecuted in court lead to convictions.¹⁷

^f The Kenya Medical Supplies Agency is a specialized medical logistics organization whose mandate is to procure, warehouse and distribute medical commodities to all public health facilities in the country.

As seen above, the limited awareness by health care workers about the various types of sexual offences stipulated in the Sexual Offence Act, 2006 can result in them not clearly documenting the type of complaint a survivor presents with. In the long run this can lead to cases being dismissed by the courts on technical grounds by providing a lee-way for the defendant to challenge the types of evidence presented, thus placing the prosecution at a disadvantage.

Specimen collection of sufficient standard to provide evidence in court continues to be hampered by the lack of the required equipment within the public health facilities. Such actions translate into missed opportunities for survivors to access both medical and legal services. Finally, the existing shortage of medical doctors required to examine survivors of sexual violence reporting to public health facilities, implies that the required medico-legal forms will not be duly filled in, and survivors will therefore not benefit from the medico-legal services in theory available to them. Apart from survivors being deprived of access to justice, this indirectly translates into increased vulnerability to HIV infection, unwanted pregnancies and negative case outcomes in the long run.

5. Conclusion

The VCT study is the first to provide an overview of current practices in the collection, storage, analysis, and preservation of evidence of sexual abuse in resource-poor settings in Kenya, focusing on the role of the health care workers. It points to the need for the development of a comprehensive national framework to address cases of SV, in order to regulate the collection of medico-legal evidence from survivors, while strengthening linkages between the health sector and the criminal justice system. Mechanisms need to be established whereby all service providers handling cases of sexual violence are trained in the provisions of the SOA; on the importance of proper evidence collection; and the crucial role of documentation of SV cases as part of the requisite medico-legal evidence. Specialized training of health care workers and police officers is critical for the successful prosecution of cases of SV due to the essential role they play in the collection and documentation of criminal evidence following a sexual assault.

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Ethical approval

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Conflict of interest

None.

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